STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		155406	A. BUILDING		03/17/2011
			B. WING		
NAME OF F	ROVIDER OR SUPPLIER	t		ADDRESS, CITY, STATE, ZIP CODE	
				EST BOULEVARD	
HICKOR	Y CREEK AT PERU		PERU	, IN46970	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000			F0000	(Email Delivery)	
10000	This visit was fo	r a Recertification and	10000	, ,	
				April 8, 2011	
	State Licensure survey.				
				Ms. Kim Rhoades, Director	
	Survey Dates:			Division of Long Term Care	
	March 14, 15, 16	6, and 17, 2011		INDIANA STATE DEPARTME	NT
	, . , . , .	., , .		OF HEALTH	
	Eagility Nymhan	. 000475		2 North Meridian Street, Secti	on
	Facility Number			4-B	000
	Provider Numbe			Indianapolis, Indiana 46204-3	006
	AIM Number: 1	00290540		RE: Hickory Creek at Peru	
	Survey Team:			Provide	er
	Julie Wagoner, R	RN TC		155400	
	Tim Long, RN	., 10		No: 155406	
	•	I (N. f. 1 1 4 15 117		Recertification and Sta	ate
		N (March 14, 15, and 17,		Licensure Survey	
	2011)			Survey Event ID #	
				OZLJ11	
	Census Bed Type	e:			
	SNF/NF: 34				
	Total: 34			Dear Ms. Rhoades:	
				Attached for your review and	
	C D T			anticipated approval, you will	find
	Census Payor Ty	pe.		the revised form requested by	
	Medicare: 03			Brenda Meredith, RN, CMS -	l l
	Medicaid: 24			2567L Statement of Deficienc	l l
	Other: 7			and Plan of Correction for the	
	Total: 34			recent annual survey. Survey	
	-			conducted March 14, 2010	
	Sample: 10			through March 17, 2010, at	
	Sample. 10			Hickory Creek at Peru, 390 W	
		_		Boulevard, Peru, Indiana 469	70.
	=	also reflects state		Diagon ha advis ad the till	
	findings cited in	accordance with 410 IAC		Please be advised that it is ou	ır [
	16.2.			intent to have this plan of correction also serve as our	
				Allegation of Compliance.	
				Allegation of Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:

OZLJ11

Facility ID: 000475 (X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155406	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 390 WEST BOULEVARD PERU, IN46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	REGULATORY OR	under the control of		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	arch of 2010 ENT		
				Street, Section 4-B Indianapo			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OZLJ11

Facility ID:

000475 If continuation sheet

Page 2 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	COMPLETED		
		155406	B. WING		03/17/2011		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 390 WEST BOULEVARD PERU, IN46970				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
				Indiana 46204-3006 RE: Hic Creek at Peru Provider 155406Recertification and St Licensure Survey Survey Eve ID # OZLJ11 Dear Ms. Rhoad Attached for your review and anticipated approval, you will the completed form CMS - 2 Statement of Deficiencies and Plan of Correction for the recent annual survey. Survey conduct March 14, 2010 through March 17, 2010, at Hickory Creek at Peru, 390 West Boulevard, Plandiana 46970. Please be advised that it is our intent to have this plan of correction a serve as our Allegation of Compliance. Compliance is effective on March 31, 2010. Should you have questions regarding the attached Plan of Correction / Allegation of Compliance, please do not hesitate to contact me. Since Ruth Fuchs Administrator co: Tom Adams, Director of Operations – Hickory Creek Healthcare Foundation Bre Waymire, Vice President of Operations - Hickory Creek Healthcare Foundation Bre Waymire, Vice President of Operations - Hickory Creek Healthcare Foundation Survey Book Sur FileThis Plan of Correction constitutes the written allegat of compliance for the deficiency of this Plan of Correction is not admission that a deficiency e or that one was cited correct. This Plan of Correction is	ate ent des: find 567L d ent cted ch iteru, lso of rely, nt vey ion acies of an xists		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155406	A. BUILDING		03/17/2011
		100400	B. WING	ADDRESS OF VICTATE ZID CODE	00/11/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE EST BOULEVARD	
	Y CREEK AT PERU		PERU,	IN46970	_
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	submitted to meet requirement established by state and feder law. Hickory Creek at Peru desires this Plan of Correction be considered the facility's Allegation of Compliance. Compliance is effective on Ma 31, 2011	ts ral to

li i		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION		A. BUILDING			COMPLETED	
		155406	B. WING			03/17/2	011
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TICK OD.	Y CREEK AT PERU		390 WEST BOULEVARD PERU, IN46970				
					11140970		71 - 0
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0282	Based on ob	servation, record	F02	82	This Plan of Correction constitute the written allegation of compliar		03/31/2011
SS=E	review, and interviews, the facility failed to ensure				for the deficiencies cited. However	er,	
					submission of this Plan of Correc is not an admission that a deficier		
	physician or	ders were followed			exists or that one was cited correct	-	
	•	sidents reviewed			This Plan of Correction is submit		
		sample of 10			to meet requirements established state and federal law.	by	
		•					
	`	10), and for 3 of 5			Hickory Creek at Peru desires this Plan of Correction to be considered		
		riewed for diabetic			the facility's Allegation of		
	monitoring in a sample of 10.				Compliance. Compliance is effect	ctive	
	(Residents #	13, 21, and 25)			on March 31, 2011		
		,			F282		
	Findings inc	lude:			What corrective action will be do by the facility?	ne_	
	1. The clinic	cal record for			-		
	Resident #25	was reviewed on			Resident #10's mat is currently		
	03/16/11 at 1				present in the room. As soon as concern was brought to facility's		
		5 was admitted to			attention the mat was placed on the		
					floor and any staff present were		
	the facility o	on $03/26/03$ with a			inserviced immediately. All othe staff were inserviced on 3/22/201		
	diagnosis, in	cluding but not			-	<u></u>	
	limited to, di	iabetes mellitus.			Residents #25, 21, and 13's blood		
		20111 physician			sugar parameters have been revie and clarified with the physician.		
		ded orders to assess			parameters will be clarified so that	<u>at</u>	
					the staff is required to call the doc rather than faxing with any blood		
		s blood sugar levels			sugars that are outside of the order		
	twice a day a	and call the			parameters. Nurses inserviced on	-	
	physician if	the resident's blood			3/22/2011 and Director of Nursin		
					reviewed the Diabetic Testing pol	ncy_	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155406	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 390 WEST BOULEVARD PERU, IN46970				
(X4) ID PREFIX TAG	sumary s (EACH DEFICIEN REGULATORY OR sugar was be above 350 d physician if sugar was be above 300 d the March 20 blood sugar indicated the sugar was 61 03/14/11 at 1 was 59 dg/m 4:00 P.M. Review of th Administrati March 2011, Notes for March Blood Sugar	elow 60 dg/ml or g/ml and to fax the the resident's blood elow 70 dg/ml or g/ml. Review of 011 glucometer checks flow sheet e resident's blood		PERU, ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) and procedure. How will the facility identify other residents having the potential to affected by the same practice and what corrective action will be tall. An audit was performed on residents in regards to bedsomat usage. Any residents whave an order for a bed mat now have a symbol outside their door to identify the net for a bedside mat. All staff inserviced on this system of 3/22/2011. An audit was performed for residents requiring blood sumonitoring. The orders for residents requiring blood sumonitoring were reviewed a clarified with the physician Nurses and QMAs were inserviced on the Diabetic Testing Policy and Procedu	eer be leer leer leer leer leer leer lee	(X5) COMPLETION DATE
	copies of fax physicians for indicated the or phone cal	•			on 3/22/2011 - What measures will be put place to ensure this practice does not recur? - When an order is received for the second sec	<u>}_</u>	

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IT OF DEFICIENCIES OF CORRECTION	II I			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155406	B. WIN			03/17/2011
PROVIDER OR SUPPLIER Y CREEK AT PERU		STREET ADDRESS, CITY, STATE, ZIP CODE 390 WEST BOULEVARD PERU, IN46970			
Interview wi Nurse Consultant documentation had been call regarding the blood sugar. 2. The clinic Resident #21 the facility of the summary of the sugar the facility of the summary of the facility of the summary of the facility of the summary of	th the Corporate altant, Registered to 03/17/11 at 2:30 ted there was no on the physician led and/or faxed e resident's low levels.		390 WE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) a bedside mat, a symbol will be placed outside the resident is room. The need for a bedside mat will be placed of the C.N.A. assignment sheet and the resident's careplant is be updated. The diabetic monitoring flow sheet will be kept in the Medication Administration Record in the front of each patient's record. The parameters will be clearly stated at the top of each flow sheet. The nurses will notify the physician and record the blood sugar as stated in the patient's physician order. The blood sugar will also be listed on the 24 hour report to be monitored by Director of Nursing and/or designee 5	DATE I Int' on t vill w V The
limited to, di The February orders include initiated on the resident's twice a day a	abetes mellitus. y 2011 physician's			In addition, the Interdisciplinary Team will review focused charting and 24 hours reports daily in the Daily Stand up Meeting to ensure that all orders are followed per physician recommendations.	I

000475

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155406	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011	
	PROVIDER OR SUPPLIER		B. WING OS/17/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 390 WEST BOULEVARD PERU, IN46970				
HICKOR (X4) ID PREFIX TAG	summary s (EACH DEFICIENT REGULATORY OR sugar level v above 350 (of Review of a 01/20/11, as indicated the A.M. b/s (b) (patient) ver oj (orange ju given et (and et milk given of Nursing) (nurse's name A.M. b/s 99 doctor) faxe n/o (new ord Interview w nurse consult 03/17/11 at 2 indicated the documentati had been call	ratement of deficiencies cy Must be perceded by full lsc identifying information) vas below 55 or dg/ml). nurse's note, dated a late entry following: "8 lood sugar) 46 pt y hard to respond. The provided by hard to respond	PF			d s 5 of ly ic re. the s to or l ed,	(X5) COMPLETION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155406	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 390 WEST BOULEVARD PERU, IN46970					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLI	ETED
		155406	B. WIN			03/17/20)11
			D		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				EST BOULEVARD		
HICKOR'	Y CREEK AT PERU				IN46970		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0282	3. Resident #10's	clinical record was	F02	82	This Plan of Correction constitute		03/31/2011
SS=E	reviewed on 3/16	5/10 at 1:30 P.M. The			the written allegation of compliar		
00 _	record indicated	the resident was admitted			for the deficiencies cited. However		
	to the facility ori	ginally on 7/10/09 and			submission of this Plan of Correct is not an admission that a deficient		
	,	facility on 1/12/11. The			exists or that one was cited correct		
		•			This Plan of Correction is submit		
	resident's diagnoses included, but were not limited to, dementia and congestive				to meet requirements established		
	heart failure.	intentia and congestive			state and federal law.		
					Hickory Creek at Peru desires thi	$_{\rm s}$	l
	An observation o	on 3/16/11 at 2:30 P.M.			Plan of Correction to be considered		
	and later at 3:15 P.M., indicated the				the facility's Allegation of		
		g in bed sleeping with no			Compliance. Compliance is effect	ctive	
	-	beside the bed. An			on March 31, 2011		
		/17/11 at 11:30 A.M.,			F282		
		dent was lying in bed					
	with no mat on th	ne floor beside his bed.			What corrective action will be do by the facility?	<u>ne</u>	
	Review of the res	sident's physician's orders					
		3/11 a physician's order			_		
		a mat on floor at bedside			Resident #10's mat is currently		
	for safety.	a mat on moor at bedside			present in the room. As soon as		
	101 saicty.				concern was brought to facility's		
	D. I. Cd	ald and taken discissing			attention the mat was placed on the floor and any staff present were	ic_	
		sident's interdisciplinary			inserviced immediately. All other	,	
	•	for falls dated 1/26/11			staff were inserviced on 3/22/201		
	indicated mat on	floor at bedside.				_	
					Residents #25, 21, and 13's blood	<u>1</u>	
	Review of the res	sident's most recent fall			sugar parameters have been revie	wed_	
	risk assessment,	dated 2/10/11, indicated			and clarified with the physician.		
	·	ed 13 which placed the			parameters will be clarified so that		
		isk for potential falls.			the staff is required to call the doo		
		- F			rather than faxing with any blood		
	Review of the Ch	NA assignment sheet			sugars that are outside of the order parameters. Nurses inserviced on		
		_			3/22/2011 and Director of Nursin	- 1	
	usea on 3/14/11 1	indicated the resident was			reviewed the Diabetic Testing pol		l
			1			<u></u>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155406	B. WIN			03/17/2	011
NAME OF	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE		
HICKOD	V CDEEK AT DEDI			1	EST BOULEVARD		
	Y CREEK AT PERU			PERU,	IN46970		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	.	,		IAG	and procedure.		DATE
	to have a mat on	noor at bedside.			and procedure.		
		th the Administrator on			How will the facility identify other	er_	
	3/17/11 at 12:15 P.M., indicated the resident is to have a mat on the floor at				residents having the potential to b		
					affected by the same practice and		
	bedside when he				what corrective action will be tak	en?	
	Administrator indicated she had observed the mat on the floor at bedside when she				An audit was performed on	all	
	was in his room in the morning of				residents in regards to bedsi		
	was in his room in the morning of 3/17/11. The Administrator indicated the				mat usage. Any residents w		
					have an order for a bed mat	110	
	mat at bedside was initiated as a				now have a symbol outside		
	1 -	easure and the resident			their door to identify the nee	ad	
	had not had any	falls previously.			for a bedside mat. All staff		
	4 B :1	1			inserviced on this system or		
		s clinical record was			3/22/2011.	I	
		6/11 at 10:45 P.M. The			3/22/2011.		
		the resident was admitted			Am audit was manfammed fan	a11	
		12/23/09. The resident			An audit was performed for		
		cluding, but not limited			residents requiring blood su	_	
	to, insulin depen	dant diabetes mellitus.			monitoring. The orders for a		
					residents requiring blood su	-	
		sident's physician's			monitoring were reviewed a		
		/11, indicated a the			clarified with the physician.		
	1 ^ -	to check blood sugar			Nurses and QMAs were		
	1	physician's orders			inserviced on the Diabetic		
		ysician is to be notified if			Testing Policy and Procedur	re	
	the resident has l	blood sugar under 50 or			on 3/22/2011		
	over 350.				-		
					What measures will be put i		
	Review of the re	sident's glucometer			place to ensure this practice	-	
	checks, dated 1/2	28/11, indicated at 4:00			does not recur?		
	P.M., the residen	nt had a blood sugar result			-		
	of 351. Review of	of the nurse's notes of			When an order is received for	or	

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155406	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPL 03/17/20	ETED
PROVIDER OR SUPPLIER		B. WING O3/17/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 390 WEST BOULEVARD PERU, IN46970				
SUMMARY S (EACH DEFICIEN REGULATORY OR 1/28/11, indicate notified of the bl An interview wit nursing) on 3/17, indicated the fact physician being is sugar of 351 on a Review of the fact procedure, titled, as reviewed on 0 administrator, inciding time an notification if blo above or below r	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) d the physician was not cood sugar over 350. h the DN (director of /11 at 2:45 P.M., ility had no record of the notified of the blood 1/28/11.		STREET A	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) a bedside mat, a symbol will be placed outside the reside s room. The need for a bedside mat will be placed of the C.N.A. assignment sheel and the resident's careplant be updated. The diabetic monitoring flow sheet will be kept in the Medication Administration Record in the front of each patient's record. The parameters will be clearly stated at the top of each flow sheet. The nurses will notified the physician and record the blood sugar as stated in the patient's physician order. The blood sugar will also be list on the 24 hour report to be monitored by Director of Nursing and/or designee 5 times a week. In addition, the Interdisciplinary Team will	l nt' on t will w	(X5) COMPLETION DATE
				review focused charting and 24 hours reports daily in the Daily Stand up Meeting to ensure that all orders are followed per physician recommendations.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER: 155406	A. BUILDING		COMP	COMPLETED 03/17/2011	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT PERU			B. WING GS/17/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 390 WEST BOULEVARD PERU, IN46970				
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	LD BE	(X5) COMPLETION DATE	
				How will corrective action monitored to ensure the def practice does not recur and will be put into place? Director of Nursing or designee will review for charting and 24 hour reactive as per week. The Director of Nursing will complete as QA for 90 days to monit compliance with the Director of Nursing Policy and Proceed The DON or designee will be results of their audits and react the monthly QA&A commit further review. After 90 days when 100% compliance is any further monitoring will completed as recommended QA&A committee. Date of compliance: March 31, 2011	cused ports 5 ctor of a daily ttor abetic cedure. oring the views to ttee for s and obtained, be		